

1. GENERAL INFORMATION

Insurance Company Name	Cigna Health & Life Insurance Company
NAIC Company Code	67369
HIOS Issuer ID	55409
State	Texas
Market Type	Individual
Proposed Effective Date	01/01/2017
Primary Contact Person and Title	Minhe Yu, FSA, MAAA, Actuarial Manager
Primary Contact Telephone Number	(860) 226-0342
Primary Contact Email	Minhe.Yu@Cigna.com

Scope and Purpose of Filing: Cigna Health & Life Insurance Company (CHLIC) is filing rates for comprehensive major medical product 55409TX006 for individuals & families, to be effective January 1, 2017. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to an existing product that has been submitted under policy form filing INDTXEPO042016. This policy form is not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

2. PROPOSED RATE INCREASE

The proposed weighted average annual rate change by product, without the impact of aging, is provided below. The rate change reflects the weighted average rate change for all 2016 plans being mapped into a 2017 plan. Section 21 provides the detailed mapping of terminating plans to 2017 plans that was used for the development of the proposed rate change.

2017 HIOS Product ID	55409TX006
Proposed Rate Change	35.2%

Please note that the Proposed Rate Change above does not equal the Product Rate Increase shown in Section I, Worksheet 2 of the URRT. As stated on page 37 of the Unified Rate Review Instructions, the Product Rate Increase Percent (over Experience Period) of 36.8% in the URRT reflects the average rate increase of the renewing plans based on the Projected Member Months. This field is calculated by the template and does not include the impact on membership mapped from a terminated plan to a new or renewing plan. Additionally, there will be further discrepancy if the projected membership by plan differs from the actual membership by plan in the experience period.

The following factors are the main drivers of the proposed rate change:

- Medical inflation and unit cost changes of medical services year over year: The underlying claim costs are expected to increase from 2016 to 2017, which is reflective of anticipated changes in the prices of medical services, the frequency with which consumers utilize services, as well as any changes in network contracts or provider payment mechanisms.
- The non-grandfathered individual marketplace is evolving in light of the material segment changes initiated by the Patient Protection and Affordable Care Act (PPACA), such as the introduction of the guaranteed issue requirement, modified community rating, subsidies, the risk adjustment program, transitional policy allowances, and many other provisions. After consideration for expected risk adjustment transfers, the single risk pool experience for CHLIC in Texas was more adverse than assumed in the current rates. As a result, CHLIC's best estimate of the average market-wide morbidity of the covered population has increased compared to 2016.
- Transitional Reinsurance Program Changes: As proposed in the 2017 HHS Notice of Benefits and Payment Parameters, the reinsurance program will end with the 2016 benefit year. Consequently, there will be no reduction in claim costs due to the program in 2017, driving an increase in premiums compared to 2016.
- Plan design changes and benefit modifications: Changes have been made to certain plans that are resulting in a decrease in CHLIC's expected cost share and therefore a decrease to premium. All plan designs conform to actuarial value and essential health benefit requirements.
- Health Insurance Industry Fee Changes: The suspension of the HII Fee for 2017 results in a decrease to premium compared to 2016.

The requested rate change is not the same across all plans. The following factors drive different rate changes by plan:

- Differences in provider network, delivery system, and utilization management across plans
- Plan design changes
- Trend leveraging due to member cost sharing provisions
- CHLIC has made refinements to the manual rating methodology and refreshed the claim probability distribution (CPD) used in the development of the cost sharing for its plans based on its most recent group experience, which leads to different cost share and expected claim cost changes among plans
- CHLIC has updated the data and methodology used to project changes to customer utilization patterns as a result of changes in cost sharing

3. EXPERIENCE PERIOD PREMIUM & CLAIMS

- a. **Paid Through Date:** December 31, 2015
- b. **Premiums in Experience Period:** Premiums in experience period represent actual 2015 premiums received through 12/31/2015 plus actual risk adjustment transfers.
 - i. Prior to MLR Rebates: [REDACTED]
 - ii. Expected MLR Rebates: [REDACTED]
 - iii. Net of MLR Rebates: [REDACTED]
- c. **Allowed & Incurred Claims:**
All claims are processed through CHLIC's claim system. Allowed claims shown below represent the sum of payments made under the policy to healthcare providers.

IBNR claims are calculated using completion factors, which represent the known paid claims as a percent of the estimated total accrual as of a particular lag period after a service month. Completion factors for a given reporting period are developed based on historical run-out patterns for national Individual experience, adjusted for actuarial judgment regarding deviance from the average (within a reasonable range based on historical deviance). The methodology used to calculate IBNR does not differ for allowed claims versus incurred claims.

[REDACTED]

4. BENEFIT CATEGORIES

To determine benefit categories, CHLIC uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Prescription Drug: Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

5. PROJECTION FACTORS

The Projection Factors described below are included in Section II, Worksheet 1 of the URRT.

- **Changes in the Morbidity of the Population Insured:** Experience was adjusted to account for expected morbidity differences between the underlying experience population and the projected 2017 population. The morbidity adjustment factor accounts for morbidity drivers specific to CHLIC's single risk pool, including the membership distribution by metal tier, cost-share reduction subsidy status, and network type.
- **Changes in Benefits:** The adjustment for changes in benefits was derived by comparing the average manual allowed claim cost for the 2017 product portfolio, weighted by projected 2017 membership by plan, to the average manual allowed claim cost for the 2015 product portfolio, weighted by 2015 CHLIC experience membership by plan. This adjustment captures anticipated changes in average utilization of services due to differences between the average member cost-sharing during the experience period and the expected average member cost-sharing in the projection period.
- **Changes in Demographics:** An adjustment was made to account for the change in distribution by age and gender between the 2015 underlying experience and the expected 2017 membership. The adjustment factor was developed as the ratio of the membership-weighted average demographic factor using 2017 projected membership, and a similar factor computed using the 2015 actual membership. An area adjustment was also made to reflect differences between the distribution of membership across rating areas in our experience population and our 2017 projected population.
- **Trend Factors:** The source data to determine the trend is national group experience adjusted for market-specific differences. Adjustments were made to account for differences in utilization across major service categories and differences in the formulary and network between group and individual. CHLIC's 2015 single risk pool experience is trended forward two years to 2017. The trend for group is deemed appropriate for use in development of individual rates because the networks constructed for group and individual are similar, and any differences in network are captured by a separate network savings decrement.

6. CREDIBILITY MANUAL RATE DEVELOPMENT

a. Source & Appropriateness of Experience Data used in Developing the Manual Rate

The source data used to generate the Manual Rate is trended national group experience adjusted for state- and market-specific differences. The experience for the national group book of business is deemed appropriate for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are similar to the benefits required to be ACA compliant. The adjustments to the baseline data are addressed below.

b. Adjustments made to the Data

The following adjustments were made during the development of the Manual Rate to account for differences between the source data and characteristics of the anticipated population in the Individual Market for the proposed period:

- **Morbidity Load – A** [REDACTED] load was added to the manual rate to account for the difference in morbidity risk of the population underlying the manual rate and the anticipated Individual population in 2017. CHLIC relied on full-year 2015 allowed claims and enrollment data for the Individual market. The morbidity load comprehends the following components:
 - Overall health status in the Individual marketplace – Customers seeking coverage through the Individual market tend to have a different average health status than those who receive coverage through their employer. The average morbidity in the Individual market is driven by external factors such as the strength of the individual mandate, overall awareness of Individual health insurance products, and the presence or absence of transitional policies. All such factors are included in the morbidity load.
 - Membership distribution by metal tier – In the Individual market, individuals tend to select plans that best meet their health needs. Riskier individuals tend to choose plans with lower member cost-share. The expected membership distribution by metal tier therefore impacts the overall expected morbidity in the single risk pool. This adjustment is applied to the index rate only and no plan-specific adjustments are made to account for anticipated differences in health status of enrollees across plans.
- **Demographic Adjustment –** The experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, an adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2017 individual market than the distribution by age reflected in the data underlying the Manual Rate.

- Impact of EHB – Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a [REDACTED] load.
- Network Savings – CHLIC’s underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. The estimated savings of the provider network vary by geographic region, but are incorporated into the Manual Rate based on assumed enrollment by region as an average 2017 [REDACTED] decrement.
- Pharmacy Formulary Savings – Pharmacy claim cost experience used in the development of the Manual Rate is based on national group experience. This group experience is representative of a broader formulary than the formulary associated with CHLIC’s individual product. The narrower formulary results in a savings of [REDACTED] on pharmacy claim costs compared to the Manual Rate.

c. Inclusion of Capitation Payments

There are no services provided under a capitation arrangement for plans included in this filing.

7. CREDIBILITY OF EXPERIENCE

Limited fluctuation credibility was used to determine the credibility assigned to the 2015 single risk pool experience. 2015 exposure of 100,000 member months was assigned 100% credibility. Therefore, the credibility assigned to 2015 single risk pool experience was [REDACTED].

8. PAID TO ALLOWED RATIO

The expected cost-sharing ratio for each benefit plan is calculated by using group experience trended to the proposed filing period to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-sharing estimates. The expected Paid-to-Allowed Ratio for the 2017 single risk pool is [REDACTED].

Some differences exist between the cost-sharing as calculated above and the Metal AVs that are described in Section 18 of this document. These dissimilarities exist as a result of the following differences in methodology:

- The CPD used to calculate member and insurer cost-share is different from the underlying claims distribution in the continuance tables of the AV Calculator. The continuance tables are based on the default standard population developed by HHS using claims and enrollment from a national commercial database. The CPD is based on claims and enrollment data from CHLIC’s national group book of business. This experience-based CPD has a larger volume of its distribution at the tail, which represents higher average costs.
- The underlying cost assumptions for copays are different in the AV Calculator as compared to CHLIC’s experience. Since most of the proposed plans represented in this filing have copay based cost-sharing for Primary Care Physician and Specialist office visits and some plans have copays on additional services, this causes a difference between the Paid-to-Allowed ratio and the Metal AV for most plans.
- Cost-sharing for other benefits, such as separate copays for urgent care, is not captured in the AV Tool, whereas CHLIC takes these benefits into account when deriving the paid-to-allowed ratio.

Note that the Paid-to-Allowed ratio as shown above is CHLIC’s best-estimate of the total expected paid claims that are the liability of CHLIC, divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in the Projection Period. The URRT does not accurately demonstrate the process used by CHLIC in the development of rates. As a result, in order to accurately reflect CHLIC’s Projected Allowed Experience Claims, Single Risk Pool Gross Average Premium, Risk Adjustment, and Expense assumptions in the URRT, an adjustment factor of [REDACTED] was applied to the Paid-to-Allowed ratio in Worksheet 1, cell V33 of the URRT.

9. RISK ADJUSTMENT & REINSURANCE

a. Experience Period Risk Adjustment and Reinsurance Adjustments (PMPM)

Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year as published by CMS on June 30, 2016 was used for obtaining the actual 2015 reinsurance and risk adjustment receivable for CHLIC in Texas.

b. Projected Risk Adjustments (PMPM)

A 2017 net risk transfer [REDACTED] PMPM is assumed. This total includes a projected risk transfer [REDACTED] PMPM and risk adjustment user fees of [REDACTED] PMPM, both on an allowed basis. Equivalently, the projected risk transfer on a paid basis is [REDACTED] with risk adjustment user fees of \$0.13 PMPM.

The risk transfer formula was used for the calculation of CHLIC's 2017 risk transfer. Components of the transfer formula were estimated at the product level, providing an estimate of the paid risk transfer PMPM at the product level. Product-level transfer PMPM estimates were combined based on membership projections by product to produce a single transfer estimate for the single risk pool.

The components of the transfer formula are outlined below with a description of the methodology used to estimate each component. In risk transfer projections, Cigna has relied upon the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year as published by CMS on June 30, 2016 to develop projections for market level risk adjustment components.

Market-Average Risk Transfer Components

- Market average factor including risk (MAF including risk) – [REDACTED]
- Market average factor excluding risk (MAF excluding risk) – [REDACTED]
- Statewide average premium (SAP) – [REDACTED]

CHLIC Risk Transfer Components

- Induced Demand Factor (IDF) – Weighted average of HHS Risk Adjustment Model IDFs based on projected 2017 CHLIC membership by metal tier
- Geographic Cost Factor (GCF) – Weighted average of 2015 actual GCFs as released by CMS based on projected 2017 CHLIC membership by rating area
- Actuarial Value (AV) – Weighted average of HHS Risk Adjustment Model AV factors based on projected 2017 CHLIC membership by metal tier
- Allowable Rating Factor (ARF) – Weighted average of HHS Risk Adjustment Model ARFs based on projected 2017 CHLIC membership by age
- Plan Liability Risk Score (PLRS) – The projected change in morbidity of CHLIC's single risk pool from 2015 to 2017 was estimated as outlined in Section 5 of this document. The projected change in morbidity was used to estimate a projected change in PLRS for CHLIC's single risk pool from 2015 to 2017. The 2017 PLRS was also adjusted for expected changes as a result of moving to the initially proposed 2017 risk adjustment model.

The projected 2017 net allowed risk transfer [REDACTED] PMPM was applied to the Index Rate in the development of the Market Average Index Rate and does not match cell V35 on Worksheet 1 of the URRT, which is on a paid basis. The impact of net risk adjustment is a [REDACTED] of CHLIC's 2017 premiums.

CHLIC does not anticipate any fees or receipts from the risk corridor program in 2017 and has not included any pricing adjustments for risk corridor payments in rate development.

c. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

As proposed in the 2017 HHS Notice of Benefits and Payment Parameters, the reinsurance program will end with the 2016 benefit year. Consequently, no reinsurance recoveries have been applied to the Index Rate in the development of the Market Average Index Rate.

10. NON-BENEFIT EXPENSES, PROFIT, & RISK

The following table illustrates anticipated breakdown of the retention components. [REDACTED] This equates to [REDACTED] and is derived based on the projected expenses as a portion of projected average statewide premium with a target loss ratio of [REDACTED].

Actual expenses on both a PMPM and percentage of premium basis will vary based on the actual size and distribution of membership by age and plan.

[REDACTED]

a. Administrative expense load

CHLIC's non-medical expenses are split out as follows:

- Acquisition administrative expense – this includes, but is not limited to, incentive compensation & salaries for brokers and agents, commissions[†], marketing costs (working media & non-working media), and vendor fees.
- Recurring administrative expense – this includes, but is not limited to, costs relating to customer analytics, service operations, account management, and corporate overhead.

The administrative expense load is based on internal estimates from CHLIC's Financial Analysis team and is deemed appropriate for the plans proposed in this filing. To determine this load, membership for CHLIC's benefit plans is projected as outlined in Section 20. This membership is then applied to known budgeted amounts for administrative expenses to determine an appropriate administrative load across all plans as a percentage of premium allocation. [REDACTED]

[†] [REDACTED]

b. Profit & Risk Margin

CHLIC has targeted a [REDACTED] profit margin that is built into its premium rates. [REDACTED] In the event that actual membership size and distribution differs from expectations, the actual profit margin may vary. There is no additional risk margin load.

c. Taxes & Fees

Please note that this section excludes contributions to the risk adjustment user fees, since these fees are included in the projected risk transfer, per Section 4.4.8 of the 2017 Unified Rate Review Instructions.

- Premium Tax is applied as 1.79% of premium
- PCORI Fee is applied as \$2.26 PMPY or 0.03% of premium

11. PROJECTED LOSS RATIO

The projected 2017 PPACA MLR, without adjustment for credibility, for CHLIC's individual products is [REDACTED].

A demonstration of the projected MLR calculation is illustrated below:

[REDACTED]

* Quality Improvement Activities, Risk Adjustment & Risk Corridor Receipts

** Premium/Payroll/Federal Income Tax and ACA Fee Adjustments

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell X47 in Worksheet 1 URRT.
- Incurred Claims – projections for incurred claims are consistent with Cell X34 in Worksheet 1 of the URRT.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2017 (Final Rule)
- Earned Premium – projections for earned premium are developed by applying the projected average rate PMPM from cell V43 in Worksheet 1 of the URRT to the expected member months projections specified earlier.
- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2017 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

12. SINGLE RISK POOL

CHLIC has included all covered lives for every non-grandfathered product/plan combination in the individual market in Texas in the single risk pool, as specified in 45 CFR 156.80(d). Please note that CHLIC does not have any transitional policies.

13. INDEX RATE

The Index Rate of the Experience Period for this filing is [REDACTED]. The Index Rate of the Experience Period in Section I, Worksheet 1 of the URRT represents the total combined 2015 allowed claims experience PMPM attributable to Essential Health Benefits in the single risk pool. It is consistent with the Experience Period Allowed Claims PMPM, as shown in Section II, Worksheet 1 of the URRT, since no benefits in addition to EHBs were offered in the experience period.

The Index Rate for the Projection Period for this filing is [REDACTED] and was developed in accordance with 45 CFR Part 156.80(d). The Index Rate for the Projection Period identified in Section III, Worksheet 1 of the URRT was generated using the same methodology as used in determining the Single Risk Pool Gross Premium Average Rate in Cell V43 of Worksheet 1 in the URRT. Hence, the Projected Index Rate is a representation of the Expected Allowed Claims for 2017 attributable to Essential Health Benefits, and incorporates the impact of trend, benefit, morbidity, and demographic adjustments as outlined in Sections 5 and 6 of this document. Refer to Section 7 of this document for additional information regarding the credibility attributed to single risk pool experience in the development of the Index Rate for the Projection Period. There are no benefits in addition to EHBs that are being covered under the proposed plans in 2017. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing.

14. MARKET ADJUSTED INDEX RATE

The Market Adjusted Index Rate for this filing is [REDACTED]. The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156.80 (d)(1). The following market-wide adjustments have been made to the Index Rate, as allowed under these rules:

- Risk Transfer - The Index Rate has been adjusted for the net transfer from the risk adjustment program. This adjustment equates to an impact of [REDACTED] PMPM on the Index Rate.

Please refer to Risk Adjustment and Reinsurance Section (section 9) for detailed explanation of how the Risk adjustment was developed.

The Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

15. PLAN ADJUSTED INDEX RATE

a. Plan Adjusted Index Rate for the Projection Period

Only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the Market Adjusted Index Rate to arrive at the Plan Adjusted Index Rates:

- Plan-specific actuarial value and cost sharing adjustments
- Adjustment factor to remove the portion of the cost that is expected to be recouped through the premium charged for tobacco
- Administrative costs, excluding the Risk Adjustment User Fee
- Impact of Provider Network, Delivery System and UM changes

The adjustment Impact of specific eligibility categories for the catastrophic plan is not applicable since CHLIC does not plan to offer catastrophic plans in 2017.

Note that the AV and cost-sharing adjustment encompasses expected cost-sharing differences, utilization differences due to differences in cost-sharing, and an adjustment for non-tobacco user status.

The expected cost-sharing ratio for each benefit plan is calculated by using group experience over the experience period (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan.

In addition to cost sharing differences, this adjustment also includes utilization differences due to differences in cost sharing. In evaluating adjustment for utilization changes, CHLIC has relied on internal studies that used regression analysis at the major service category level, to develop a relationship between historical utilization and corresponding expected cost-sharing. This adjustment is consistent with the description on page 62 of the 2017 Unified Rate Review Instructions. There are no explicit and/or additional adjustments used in our rate development process that reflect expected differences in utilization due to health status.

The adjustment for non-tobacco user status was developed by a weighted average of the expected claim cost between tobacco-user and non-tobacco-user by an assumed distribution.

b. Plan Adjusted Index Rate for the Experience Period

The Plan Adjusted Index Rate for the Experience Period has been included in row 55 on Worksheet 2 of the URRT. This represents the expected non-calibrated statewide average premium for a non-tobacco user based on expected membership at time of 2015 Pricing. The Plan Adjusted Index Rate for the Experience Period differs from the average premium rate in Section I of Worksheet 1 due to the following items:

- Differences between projected and actual 2015 membership by age and geography
- The Plan Adjusted Index Rate represents the average projected 2015 premium for a non-tobacco user, while the average premium rate in Section I of Worksheet 1 includes non-tobacco users and tobacco users

16. CALIBRATION

CHLIC calibrates the Plan Adjusted Index Rates to apply the allowable rating factors (age and geography) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below.

a. Age Curve Calibration

The weighted average age factor for the projected membership was calculated using the Default Federal Standard Age Curve. The average age associated with this projected membership (rounded to the nearest whole number) is [REDACTED]. This single risk pool average age was determined using a blend of the current 2016 age distribution in the single risk pool and 2015 enrollment data released by CMS for CHLIC service areas. The Plan Adjusted Index Rate was divided by the weighted average age factor mentioned above, to arrive at the calibrated Plan Adjusted Index Rate for a 21 year old. A demonstration of how the Plan Adjusted Index Rate and the age curve were used to generate the calibrated Plan Adjusted Index Rate for each plan is provided below.

b. Geographic Factors

Rate variations among geographical areas vary only by the geographic rating regions defined by the federal government. Area factors reflect only differences in the cost of the delivery of medical services among rating areas for a standard population and fixed market basket of covered services. The following table shows the geographic factors for each defined area in Texas:

[REDACTED]

An average geographic factor is developed based on the projected distribution of membership across all areas. Then the calibrated Plan Adjusted Index Rate is calculated as Plan Adjusted Index Rate divided by this weighted average geographic factor.

A demonstration of calibration for the Plan Adjusted Index Rate is provided in the table below.

[REDACTED]

* The Plan Adjusted Index Rate represents average premium for the projected single risk pool at the unrounded average age, weighted using the best-estimate Default Federal Standard Age Curve factors. Linear interpolation between integer Default Federal Standard Age Curve factors was used in the development of the Demographic Calibration factor.

17. CONSUMER ADJUSTED PREMIUM RATE

Consumer Adjusted Premium Rate is developed by applying the following allowable adjustments to the calibrated Plan Adjusted Index Rate.

- Individual and family tier – applied by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account
- Rating area factor – applied by multiplying the area factors to the calibrated Plan Adjusted Index Rate
- Age factor – applied by multiplying the age factor to the calibrated Plan Adjusted Index Rate
- Tobacco status – applied by multiplying the tobacco factor calibrated to the Plan Adjusted Index Rate

18. AV METAL VALUES

The AV Metal Values shown in Worksheet 2 of the URRT for the plans listed below were based on the AV Calculator, with the exception of the following unique benefits for select plan designs:

- Cost Sharing for Pharmacy Generic Drugs
- Cost-Sharing for Pharmacy Retail vs. Home-Delivery Service
- Cost Sharing for Mental Health/Substance Abuse Outpatient Office Visit vs. Facility Visit Services
- Copays for Urgent Care Services

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). The impacted plans, alternate methodologies, and the reason for their use is explained in the accompanying actuarial certification titled “Unique Plan Design Supporting Documentation & Justification”.

19. AV PRICING VALUES

A demonstration of the development of the Plan Adjusted Index Rate from the Market Adjusted Index Rate is provided table below.

CHLIC is not incorporating any impact due to the different morbidity or health status of individuals who select certain plans in the derivation of the Pricing AV. See Section 15 in this document for an explanation of the factors used in the development of the Pricing AV.

20. MEMBERSHIP PROJECTIONS

The membership projections for CHLIC’s benefit plans are developed internally as best estimates. They were derived from CHLIC 2016 open enrollment experience and assumed channel growth in Texas. Active membership splits were used to develop projections by metal tiers, together with growth assumptions by channel.

21. TERMINATED PRODUCTS

The tables below show the plan mapping for terminating plans to new or existing plans in 2017. Blank cells indicate that plans were terminated and unmapped in 2016 or 2017.

22. PLAN TYPE

The plan types as inputted in Section I, Worksheet 2 of the URRT accurately describe the plans in this filing.

23. WARNING ALERTS

Row 57 – The Plan Adjusted Index Rate and Total Premium for the Experience Period differs from the average premium rate in Section I of Worksheet 1 due to differences in projected versus actual distribution of membership by age and geography as well as differences in projected versus actual risk adjustment transfers. Additionally, the Plan Adjusted Index Rate for the Experience Period reflects the expected premium for non-tobacco users only. See Section 15 in this document for additional information regarding the Plan Adjusted Index Rate for the Experience Period.

Row 68 & 73 – Per Worksheet 2 of the URRT, the Total Incurred claims payable with issuer funds equals allowed claims less all allowed claims which are not the issuer's obligation, including member cost-sharing, reinsurance and risk adjustment receivables or payables, and cost-sharing paid by HHS on behalf of low-income members. However, page 14 of the Universal Rate Review Instructions indicates that the Incurred Claims in Experience Period, as shown on Worksheet 1 of the URRT, is allowed claims less member cost-sharing and cost-sharing paid by HHS on behalf of low-income members. Therefore, cell F15 on Worksheet 1 of the URRT is not adjusted for expected receipts or payments for the reinsurance or risk adjustment programs for 2015, while rows 68 and 73 on Worksheet 2 are adjusted for these payments.

24. EFFECTIVE RATE REVIEW INFORMATION

a. Financial Information

Cigna Health & Life Insurance Company (CHLIC)				
(\$ Millions)	2012	2013	2014	2015
Stat Capital & Surplus	1,018	1,714	2,800	3,009
Authorized Control Level RBC	172	355	480	566

CHLIC is in strong financial condition. The YE 2015 ACL RBC ratio was 558%. In prior years when the company was significantly smaller, the RBC ratio was much higher. For the next few years, CHLIC is expected to maintain an ACL RBC ratio around [REDACTED]. The proposed plans and rates will have an immaterial impact on the company's financial condition, even with significant membership growth.

b. Rating Information

To see the proposed rate manual by age, area and smoking status please reference the accompanying QHP Rate Table Template. For additional rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying Plans Benefits Template.

Please note that CHLIC shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit, and a standalone exchange-certified pediatric dental policy.

c. Other

CHLIC's anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is [REDACTED].

25. RELIANCE

I have relied on data and analysis provided by Harsh Mota, Actuarial Senior Analyst, in developing the proposed premium rates and in preparing the Part 1 Unified Rate Review Template submission. I have also relied on claim, premium, enrollment, and risk score data supplied by Lyn Dills, Analytics Senior Specialist, and Allyssa Ward, Actuarial Specialist. The data have been reviewed for reasonableness but have not been audited. In addition, I have relied on other internal and external sources to develop the underlying assumptions used in the pricing methodology.

26. ACTUARIAL CERTIFICATION

I, Minhe Yu, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify, to the best of my knowledge and judgment, that:

- a) The rates proposed in the above noted rate filing are
 - In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
 - Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
 - ASOP #5, Incurred Health & Disability Claims

- ASOP #8, Regulatory Filings for Health Plan Entities
 - ASOP #12, Risk Classification
 - ASOP #23, Data Quality
 - ASOP #25, Credibility Procedures Applicable to Accident & Health, Group Term Life, and Property & Casualty Coverages
 - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
 - ASOP #41, Actuarial Communications
 - Reasonable in relation to the benefits provided and the population anticipated to be covered
- b) The Projected Index Rate presented in this filing is:
- a. In compliance with all applicable state and Federal statutes and regulations in 45 CFR 156.80(d)(1)
 - b. Developed in compliance with the applicable Actuarial Standards of Practice
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
 - d. Neither excessive nor deficient
- c) Plan level rates were generated using only the index rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)
- d) The geographic rating factors reflect only differences in the costs of delivery, including unit cost and provider practice pattern differences, and do not include differences for population morbidity by geographic area.
- e) The percent of total premium that represents Essential Health Benefits included in Worksheet 2, Section IV, of the Part 1 URRT was calculated in accordance with applicable Actuarial Standards of Practice
- f) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans, save the exceptions shown in Section 18, which are further explained in the accompanying actuarial certification “Unique Plan Design Supporting Documentation & Justification”.

The URRT does not demonstrate the process used to develop the rates presented in this filing. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Marketplaces, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



Minhe Yu, FSA, MAAA
Actuarial Manager
Cigna Health & Life Insurance Company
Minhe.Yu@Cigna.com